



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

APRIL 2021 HIGHLIGHTS

Congressional Testimony

Counselor to the Inspector General Testifies before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations

Mr. Christopher Wilber, counselor to the Inspector General, testified at a hearing before the House Committee on Veterans' Affairs Oversight and Investigations Subcommittee on April 21, 2021, on pending legislation including H.R. 2428, the Strengthening Oversight for Veterans Act of 2021. Mr. Wilber testified in support of the bill, which would give the VA Office of Inspector General (OIG) testimonial subpoena authority. He explained how it would strengthen the OIG's work, discussed examples of inspections and investigations where the OIG could not interview former VA employees, and noted safeguards for witnesses. Mr. Wilber also commented on other legislation that related to findings in OIG reports.

Investigations Involving Health Care

VA Choice Contractor Paid \$3.5 Million in Interest for Overpayments

A contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs entered into a final settlement agreement with the Eastern District of California to resolve allegations that it submitted duplicate invoices to VA and failed to reduce billings to VA to reflect negotiated discounts it received from private healthcare providers for services rendered. Pursuant to this agreement, the contractor made an interest payment of \$3,554,963. This settlement was the culmination of a three-year investigation conducted by the VA OIG, VA, and Department of Justice. Over the course of this investigation, this contractor returned approximately \$92.5 million in overpayments by VA due to duplicate invoice submissions.

Seven Individuals and Four Companies Plead Guilty in Connection with Healthcare Fraud Scheme

The US District Court for the District of South Carolina unsealed various judicial actions which pertained to one of the largest healthcare fraud schemes in US history. The owner of over a dozen durable medical equipment companies, six business associates, and four companies pleaded guilty to charges in connection with this investigation that resulted in charges that the defendants participated in a scheme in which telemedicine companies contracted with telemedicine doctors to prescribe orthotic braces for patients with whom there was no doctor-patient relationship. The durable medical equipment companies then submitted grossly inflated claims to federal agencies for payment. The total loss to the government is approximately \$1.2 billion. Of this amount, the total loss to VA's Civilian Health and Medical Program is over \$2.1 million. The investigation was conducted by the VA OIG, FBI,

Department of Health and Human Services (HHS) OIG, and Internal Revenue Service Criminal Investigation.

Five Individuals Arrested and Two Individuals Plead Guilty in Connection with Healthcare Fraud Scheme

Five defendants were arrested after being charged in the District of New Jersey in connection with a nationwide healthcare fraud scheme. Additionally, two defendants pleaded guilty to conspiracy to violate the anti-kickback statute and conspiracy to commit healthcare fraud. An investigation by the VA OIG, Defense Criminal Investigative Service, FBI, and HHS OIG resulted in charges that the defendants participated in a scheme which solicited durable medical equipment and cancer genetic screening tests to prospective patients and used telemarketers and telemedicine doctors to generate prescriptions. It is alleged that the telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the testing laboratory. Many of the target companies identified in the scheme submitted claims for payment to VA's Civilian Health and Medical Program. To date, investigative efforts have led to 17 arrests and 10 convictions. The total loss to VA is approximately \$330,000.

Two Defendants Plead Guilty to Theft of Government Funds

A veteran and his spouse each pleaded guilty in the Southern District of California to theft of government funds. A VA OIG investigation revealed that from October 2015 through April 2020, both defendants made numerous false statements to VA which indicated that the veteran was unemployed and in need of a full-time caregiver. During this same time frame, the veteran worked full-time as a veteran service representative at the VA regional office in San Diego, California. The loss to VA is approximately \$183,000.

Federal Contractor Charged with Bribery

A federal contractor was arrested after being charged in the Northern District of New York with bribery. A VA OIG investigation resulted in charges that the defendant offered bribes to a VA contracting officer in return for steering contracts for personal protective equipment to his company.

Former Coatesville VA Medical Center Employee Indicted for Making Threats

A former employee of the Coatesville VA Medical Center in Pennsylvania was indicted for threatening and cyberstalking his former coworkers. A VA OIG investigation resulted in charges that the defendant sent sexually explicit, harassing, and threatening interstate communications and mail packages to various former coworkers. The defendant also allegedly targeted the family members of his former coworkers with similarly vulgar communications. The defendant was indicted in the Eastern District of Pennsylvania.

Veteran Arrested for Making Threats

A veteran was arrested after being charged in the Northern District of Ohio with influencing, impeding, or retaliating against a federal employee by threatening a family member. A VA OIG investigation

resulted in this charge that the defendant sent a threatening text message to his VA social worker's government-issued cell phone after he was discharged from housing provided through the Department of Housing and Urban Development-VA Supportive Housing program due to misconduct. It is alleged that the defendant threatened to kill the social worker's family members because he blamed him for his removal from the program.

Investigation Involving Benefits

For-Profit Trade School Owner Found Guilty in Connection with Education Benefits Fraud Scheme

The owner of a heating, ventilation, and air conditioning school was found guilty by a federal jury in the Northern District of Texas on charges of wire fraud and money laundering. An investigation by the VA OIG, US Postal Inspection Service, and FBI resulted in charges that the defendant fraudulently obtained state and VA approval for his for-profit school. The defendant then allegedly used the fraudulently obtained approval status to entice veteran students to attend the school, which resulted in the fraudulent collection of VA education benefits. The loss to VA is approximately \$71 million.

Investigation Involving Other Matters

Construction Firm Paid \$2.5 Million to Resolve Criminal and Civil Investigations

The US Attorney's Office for the Central District of California announced that a construction firm agreed to a civil settlement and non-prosecution agreement under which the company paid \$2.5 million to settle allegations that it violated federal law through its involvement in federal construction contracts obtained by a related company under a program designated for small businesses owned by service-disabled veterans. Of this amount, VA will receive \$1.4 million. An investigation by the VA OIG and Small Business Administration OIG resolved allegations that from August 2007 to October 2013, a now-defunct construction company certified to VA that it qualified for service-disabled veteran-owned small business (SDVOSB) set-aside and sole source contracts. The defunct company submitted invoices to VA for multiple SDVOSB contracts, even though it was ineligible for SDVOSB status since the service-disabled owner did not control the firm on a day-to-day basis. This construction firm was closely affiliated with the defunct company, and their employees worked on that company's SDVOSB contracts.

Audit

Federal Information Security Modernization Act Audit for Fiscal Year 2020

The OIG contracted with CliftonLarsonAllen LLP (CLA) to evaluate VA's information security program compliance with the Federal Information Security Modernization Act for FY 2020. CLA evaluated 48 major applications and general support systems hosted at 24 VA sites. CLA concluded that VA continues to face significant challenges meeting requirements and made 26 recommendations. Two

recommendations from previous years were closed and three new ones were added. CLA recommended VA address security-related issues that contributed to reported information technology material weaknesses and improve deployment of security patches, system upgrades, and system configurations to mitigate significant security vulnerabilities and enforce a consistent process across all field offices. CLA also recommended VA improve performance monitoring to ensure controls operate as intended at all facilities and communicate identified security deficiencies to mitigate significant risks. CLA will follow up on the outstanding recommendations in the FY 2021 audit of VA's information security program.

National Healthcare Review

Review of Community-Based Outpatient Clinics Closed Due to the COVID-19 Pandemic

This report reviewed Veterans Health Administration (VHA) community-based outpatient clinic (CBOC) closures that occurred due to the COVID-19 pandemic to evaluate the impact of these closures on patient care. Of VHA's 1,031 CBOCs, 173 were closed to face-to-face visits on or after February 1, 2020. Reasons for closure fell into four categories including (a) safety of patients and staff due to community spread, (b) need for consolidation of resources to support larger CBOCs or facilities, (c) lack of staff and personal protective equipment, and (d) small size of the CBOC or proximity to other CBOCs or facilities. The OIG concluded that, generally, patient care needs were not interrupted due to CBOC closures. Clinicians triaged patients and offered other care delivery options such as telephone visits, VA Video Connect appointments, and outpatient visits at the parent facility, or rescheduled appointments for a later date. The OIG made no recommendations.

Healthcare Inspection

Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison

This inspection evaluated Veterans Crisis Line responses to caller 1 with homicidal ideation and caller 2 with suicidal and homicidal ideation and caller 1's primary care at the facility. The OIG substantiated a responder failed to assess caller 1's homicidal risk factors, address lethal means, complete an adequate safety plan, communicate critical information to a supervisor, and take actions to prevent a family member's death. The OIG substantiated two social service assistants (SSAs) failed to dispatch emergency services for caller 2 following a rescue request. The OIG identified SSA oversight deficiencies. A facility provider failed to include caller 1's mental health diagnosis in the assessment and did not submit caller 1's non-VA medical records for scanning or document a review. The OIG made 11 recommendations regarding quality management, review of the callers' contacts, administrative investigation boards, responders' communication, SSA oversight, and non-VA health records documentation policy compliance.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

- (1) Leadership and organizational risks
- (2) Quality, safety, and value
- (3) Credentialing and privileging
- (4) Environment of care
- (5) Medication management
- (6) Mental health care
- (7) Geriatric care
- (8) Women's health
- (9) High-risk processes

Recently published CHIP reports include:

Ann Arbor VA Medical Center in Michigan

Additional Publication

Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents

While reviewing VHA's plans to document receipt and distribution of the COVID-19 vaccine, the OIG found VHA facilities did not consistently document the COVID-19 vaccination status of veterans living in VA's Community Living Centers (CLC). The OIG determined that VHA could not know at a national level whether the vaccine was offered to some CLC residents, and if so, what their status was. Because those residents are in the highest COVID-19 vaccine priority group, they should be offered the vaccine, when possible, before other groups of veterans. With supplies limited, VHA should know which CLC residents still need to be vaccinated. The OIG will continue its oversight work on vaccinations within VHA and plans to issue a full report, including specific recommendations. In the meantime, the OIG requests to know what action, if any, VHA takes to mitigate the potential risks identified and the outcome of those actions.

To listen to the podcast on the April 2021 highlights, go to www.va.gov/oig/podcasts.